FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0033779

Facility Name: Covenant HCC Northbrook

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 480-6390 **Fax #** (847) 480-7666

HFS ID Number:

Date of Initial License for Current Owners: 01/20/1972

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name Andrew Cutler **Telephone Number:** (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/13 to 01/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015
(Telephone) (847) 374-0400 Fax # (847) 374-0420

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 11/01/2013

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,966	20,075	5,949	30,990	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,966	20,075	5,949	30,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.24%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/20/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 102 and days of care provided 5,469

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 1/31 Fiscal Year: 1/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Covenant HCC Northbrook # 0033779 **Report Period Beginning:** 02/01/13 **Ending:** 01/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	301,626	6,500	52,059	360,185		360,185		360,185			1
2	Food Purchase		350,143		350,143		350,143	(6,393)	343,750			2
3	Housekeeping	132,116	25,137	581	157,834		157,834		157,834			3
4	Laundry	30,100	14,276	101,033	145,409		145,409		145,409			4
5	Heat and Other Utilities			137,144	137,144		137,144		137,144			5
6	Maintenance	112,431	27,874	174,339	314,644		314,644	(2,282)	312,362			6
7	Other (specify):*											7
8	**TOTAL General Services**	576,273	423,930	465,156	1,465,359		1,465,359	(8,675)	1,456,684			8
	B. Health Care and Programs											
9	Medical Director			56,880	56,880		56,880		56,880			9
10	Nursing and Medical Records	2,699,240	55,071	16,604	2,770,915		2,770,915		2,770,915			10
10a	Therapy											10a
11	Activities	182,641	2,504	21,124	206,269		206,269		206,269			11
12	Social Services	114,531		150	114,681		114,681	(7,967)	106,714			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,996,412	57,575	94,758	3,148,745		3,148,745	(7,967)	3,140,778			16
	C. General Administration											
17	Administrative	86,525		427,812	514,337		514,337	(427,812)	86,525			17
18	Directors Fees											18
19	Professional Services			35,935	35,935		35,935	(128,185)	(92,250)			19
20	Dues, Fees, Subscriptions & Promotions			97,385	97,385		97,385	(80,435)	16,950			20
21	Clerical & General Office Expenses	268,750		462,216	730,966		730,966	212,671	943,637			21
22	Employee Benefits & Payroll Taxes			1,124,268	1,124,268		1,124,268		1,124,268			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,309	10,309		10,309		10,309			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			127,828	127,828		127,828		127,828			26
27	Other (specify):*											27
28	**TOTAL General Administration**	355,275		2,285,753	2,641,028		2,641,028	(423,761)	2,217,267			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,927,960	481,505	2,845,667	7,255,132		7,255,132	(440,403)	6,814,729			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant HCC Northbrook #0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			512,550	512,550		512,550	55,747	568,297			30
31	Amortization of Pre-Op. & Org.			10,460	10,460		10,460		10,460			31
32	Interest			51,255	51,255		51,255	(51,255)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,469	14,469		14,469		14,469			35
36	Other (specify):*			723	723		723		723			36
37	**TOTAL Ownership**			589,457	589,457		589,457	4,492	593,949			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		316,257	690,342	1,006,599		1,006,599		1,006,599			39
40	Barber and Beauty Shops	19,889		2,020	21,909		21,909		21,909			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,160	198,160		198,160		198,160			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	19,889	316,257	890,522	1,226,668		1,226,668		1,226,668			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,947,849	797,762	4,325,646	9,071,257		9,071,257	(435,911)	8,635,346			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,393)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	55,747	30		9
10	Interest and Other Investment Income	(51,255)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(205,256)	21		24
25	Fund Raising, Advertising and Promotional	(80,435)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(209,606)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (497,198)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,287		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 61,287		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (435,911)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Covenant HCC Northbrook

ID# 0033779

Report Period Beginning: 02/01/13

Ending: 01/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Guest Apartment Revenue	$ (328)	06	1
2	Transportation Revenue	(7,967)	12	2
3	Transfer Temp Restr For Oper	(24,165)	21	3
4	Investment Property Revenue	(1,954)	06	4
5	Other Services Revenue	(33)	21	5
6	Other Operating Revenue	(5,897)	21	6
7	Intercampus Revenue	(157,022)	21	7
8	Non-Allowable Legal	(12,240)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(209,606)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant HCC Northbrook **#** 0033779 **Report Period Beginning:** 02/01/13 **Ending:** 01/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,393)	0	0	0	0	0	0	0	0	0	0	(6,393)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,282)	0	0	0	0	0	0	0	0	0	0	(2,282)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,675)	0	0	0	0	0	0	0	0	0	0	(8,675)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(7,967)	0	0	0	0	0	0	0	0	0	0	(7,967)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(7,967)	0	0	0	0	0	0	0	0	0	0	(7,967)	16
	C. General Administration													
17	Administrative	0	(427,812)	0	0	0	0	0	0	0	0	0	(427,812)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,240)	(115,945)	0	0	0	0	0	0	0	0	0	(128,185)	19
20	Fees, Subscriptions & Promotions	(80,435)	0	0	0	0	0	0	0	0	0	0	(80,435)	20
21	Clerical & General Office Expenses	(392,373)	605,044	0	0	0	0	0	0	0	0	0	212,671	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(485,048)	61,287	0	0	0	0	0	0	0	0	0	(423,761)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(501,690)	61,287	0	0	0	0	0	0	0	0	0	(440,403)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant HCC Northbrook # 0033779 **Report Period Beginning:** 02/01/13 **Ending:** 01/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	55,747	0	0	0	0	0	0	0	0	0	0	55,747	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,255)	0	0	0	0	0	0	0	0	0	0	(51,255)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,492	0	0	0	0	0	0	0	0	0	0	4,492	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(497,198)	61,287	0	0	0	0	0	0	0	0	0	(435,911)	45

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities	100%	See 6- SUPP				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Office Expense-CRC Alloc.	$	Covenant Retirement Communities		$ 667,252	$ 667,252	1
2	V	21	Other Operating Expense	23,220	Covenant Retirement Communities			(23,220)	2
3	V	19	Consultant Services	81,931	Covenant Retirement Communities			(81,931)	3
4	V	21	In Service Fees- Software	38,988	Covenant Retirement Communities			(38,988)	4
5	V	19	Legal Services	6,944	Covenant Retirement Communities			(6,944)	5
6	V	17	Management Service Fees	427,812	Covenant Retirement Communities			(427,812)	6
7	V	19	Payroll Services	27,070	Covenant Retirement Communities			(27,070)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 605,965			$ 667,252	$ * 61,287	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jon P. Aagaard, M.D.	BOD	Covenant Village Care Center - Florida	Plantation, FL				1
2	Pamela Christensen	BOD	Michaelsen Health Center	Batavia, IL				2
3	Kara Davis	BOD	Windsor Park Manor	Carol Stream, IL				3
4	Rev. Harvey Drake	BOD	Covenant Village Care Center - Turlock	Turlock, CA				4
5	Mark Eastburg	BOD	Mount Miguel Covenant Village	Spring Valley, CA				5
6	James Elving	BOD	Samarkand Skilled Nursing	Santa Barbara, CA				6
7	Marc Espinosa	BOD	Colonial Acres Care Center	Golden Valley, MN				7
8	Carol A. Findling	BOD	Covenant Vilage of the Great Lakes	Grand Rapids, MI				8
9	Lorene G. Flewellen	BOD	Covenant Village of Colorado	Westminster, CO				9
10	Rhoda Friesen	BOD	Pilgrim Manor	Cromwell, CT				10
11	Thomas F. Heywood	BOD	Covenant Shores	Mercer Island, WA				11
12	Donald Hodgkinson	BOD						12
13	Kathy Holmgren	BOD						13
14	Judy Holt	BOD						14
15	Marlene E. Stante	BOD						15
16	Anne Vining	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
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29								29
30								30

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See PG 6-SUPP								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities
Street Address: 5700 OlD Orchard Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office Expense - CRC Allocation				$	$		$ 667,252	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 667,252	25

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	2012C Col Tax Ex Bonds		X	Capital Improvements		2012	$ 1,036,673	$ 982,001			$ 53,609	1
2	2012A Col Tax Ex Bonds		X	Capital Improvements		2012	539,199	539,199			25,410	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,575,872	$ 1,521,200			$ 79,019	9
	B. Non-Facility Related*											
10	Accretion of OIP		X								(18,321)	10
11	Capitalized Int.		X								(10,631)	11
12	Financing Assessment		X								1,188	12
13	Interest Income		X								(51,255)	13
14	TOTAL Non-Facility Related						$	$			$ (79,019)	14
15	TOTALS (line 9+line14)						$ 1,575,872	$ 1,521,200			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

N/A Facility does not pay real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant HCC Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick Masonry Frame Steel Studded Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 25,168
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 10,460
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1973	$ 70,721	1
2					2
3	TOTALS			$ 70,721	3

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102		1974	1974	$ 1,467,409	$	40	$ 36,685	$ 36,685	$ 1,467,408	4
5			1975	1975	2,250		40	56	56	2,192	5
6			1976	1976	1,916		40	48	48	1,821	6
7			1977	1977	2,769		40	69	69	2,560	7
8			1978	1978	7,643		40	191	191	6,878	8
	Improvement Type**										
9	Various			1979	18,220		20			18,220	9
10	Various			1980	20,844		20			20,844	10
11	Various			1981	38,116		20			38,116	11
12	Various			1982	17,734		20			1,709,834	12
13	Various			1984	13,999		20			16,014	13
14	Various			1985	189,803		20			180,084	14
15	Various			1986	36,791		20			42,181	15
16	Various			1987	26,840		20			23,840	16
17	Various			1988	41,929		20			41,929	17
18	Various			1989	614,857		20			501,126	18
19	Various			1990	84,534		20			121,841	19
20	Various			1991	30,632		20			4,223	20
21	Various			1992	18,213		20			18,213	21
22	Various			1993	10,084		20			10,084	22
23	Various			1994	31,384		20	425	425	8,917	23
24	Various			1995	4,965		20			4,965	24
25	Various			1996	5,267		20			5,267	25
26	Various			1997	28,305		20	599	599	10,778	26
27	Various			1998	2,109,189		20	105,459	105,459	1,792,810	27
28	Various			1999	180,129		20	9,005	9,005	144,096	28
29	Various			2000	4,050,990		20	200,835	200,835	3,012,520	29
30	Various			2001	104,552		20			104,552	30
31	Various			2002	60,740		20			60,740	31
32	Various			2003	88,626		20	1,098	1,098	13,172	32
33	Various			2004	79,166		20	3,958	3,958	43,229	33
34	Various			2005	17,390		20	870	870	8,697	34
35	Various			2006	55,760		20	2,788	2,788	25,092	35
36	Various			2007	134,749		20	6,737	6,737	50,228	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

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XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	$ 163,760	$	20	$ 9,166	$ 9,166	$ 56,170	37
38	Various	2009	90,584		20	7,831	7,831	33,426	38
39	Door Opener Replacement	2010	4,703		20	235	235	1,175	39
40	Brandel Remodeling - Architecture And Window Treatments	2010	12,741		20	637	637	2,548	40
41	Re-Key Brandel Care Center	2010	15,107		20	735	735	2,960	41
42	Plumbing Work	2010	20,600		20	1,030	1,030	3,825	42
43	Brandel Therapy Wing Remodel - Walls, Floors, Ceilings, Windov	2010	353,493		20	17,675	17,675	54,055	43
44	Walking Garden	2010	14,950		20	748	748	2,992	44
45	Brandel Wing Remodel - Architecht Fees	2012	600		20	15	15	30	45
46	BCC 100 Wing HVAC	2012	3,698		20	92	92	184	46
47	New Doors Brandel	2012	26,990		20	675	675	1,350	47
48	Brandel Insulation	2012	3,600		20	90	90	180	48
49	BCC/AL Connecting Roof	2012	18,558		20	464	464	928	49
50	BCC Roof Drains	2012	19,064		20	476	476	952	50
51	BCC HVAC Rooftop	2012	74		20	2	2	4	51
52	BCC 100 WING Door	2012	3,236		20	81	81	162	52
53	HC Fire Sprinkler	2012	8,439		20	211	211	422	53
54	Doors- Brandel	2012	22,515		20	563	563	1,126	54
55	Memory Support Unit Countertop	2012	6,340		20	158	158	316	55
56	Brandel Wing Remodel - Architecht Fees	2012	12,619		20	316	316	632	56
57	Brandel Wing Remodel-FD-Flooring, Lighting, Doors, Paint, Ceili	2012	222,126		20	5,553	5,553	11,106	57
58	Brandel Wing Remodel - SG - Fire Alarms/Fire Sprinkler Upgrad	2012	5,601		20	140	140	280	58
59	Flooring for 100 Wing Resident Rooms, 300 Dining Room, 400 Wi	2013	241,777		20	12,089	12,089	12,089	59
60	Orchard Dining Room Remodel - Flooring, Walls, Nurisng Statior	2013	34,502		20	1,725	1,725	1,725	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Financial Statement Depreciation			512,550			(512,550)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,901,472	$ 512,550		$ 429,530	$ (83,020)	$ 9,701,108	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,375,926	$	$ 137,593	$ 137,593	10	$ 1,108,335	71
72	Current Year Purchases	227,843						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,603,769	$	$ 137,593	$ 137,593		$ 1,108,335	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77		Bus	2010	5,869		1,174	1,174	5	4,696	77
78										78
79										79
80	TOTALS			$ 5,869	$	$ 1,174	$ 1,174		$ 4,696	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,581,831	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 512,550	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 568,297	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,747	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,814,139	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 14,469 Description: See Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Description	Amount
Copier	7,244.00
Therapy Equipment Lease	7,225.00
	14,469.00

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XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Covenant HCC Northbrook # 0033779 Report Period Beginning: 02/01/13 Ending: 01/31/14

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 297,314	$		$ 297,314	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			36,850			36,850	2
3	Licensed Recreational Therapist	39-03	hrs			321,709			321,709	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				316,257		316,257	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					34,469			34,469	13
14	TOTAL			$		$ 690,342	$ 316,257		$ 1,006,599	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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	Special Services - Supplies (Column 6 - Other)	Amount
13A	Nursing & Med Supp	157,903.00
13B		
13C		
13D		
13E		
13F		
13G		
13H		
13I		
13J		
		157,903.00

	Special Services - Outside (Column 5 - Other)	
13K	Laboratory And X-Ray (Lax) Expense	34,469.00
13L		
13M		
13N		
13O		
13P		
13Q		
13R		
13S		
13T		
		34,469.00

	Special Services - Outside (Column 5 - Other)	
13U		
13V		
13W		
13X		
13Y		
13Z		
		-

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XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	17,396		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	985,205		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,410		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	42,490		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,052,501	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,272		13
14	Buildings, at Historical Cost	9,924,333		14
15	Leasehold Improvements, at Historical Cost	42,526		15
16	Equipment, at Historical Cost	1,351,127		16
17	Accumulated Depreciation (book methods)	(7,567,723)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,889		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,022)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	17,022,931		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 20,862,333	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,914,834	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 112,418	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	315,597		30
31	Accrued Taxes Payable (excluding real estate taxes)	41,362		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,458		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	195,440		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 676,275	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,521,200		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,521,200	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,197,475	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 19,717,359	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,914,834	$	48

***(See instructions.)**

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	Other Current Assets:	Amount
09A	Bond Sinking Fund	29,496
09B	Bond Interest Fund	12,694
09C	Notes Recieveable- Employees	300
09D		
09E		
09F		
09G		
		42,490

	Other Non-Current Assets:	Amount
23A	Benevolent Care Fund	1,088,549
23B	Capital Reserve Fund	5,001,781
23C	Property Replacement Fund	961,501
23D	Debt Service Reserve Fund	155,421
23E	Construction In Progress-Res	10,631
23F	Original Issue Discount (OID), Net	9,122
23G	Original Issue Premium (OIP), Net	(68,170)
23H	Admin - Zone 91	9,864,567
		17,023,402

	Other Current Liabilities:	Amount
36A	Design Contributions-General	37,696
36B	Other Current Liabilities:	116,504
36C	Resident Trust Funds	17,396
36D	Deffered Maintenance	23,844
36E		
36F		
36G		
		195,440

	Other Non-Current Liabilities:	Amount
43A		
43B		
43C		

43D
43E
43F
43G

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 18,667,363	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,667,365	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,049,996	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,049,996	17
	B. Transfers (Itemize):		
18	Rounding	(2)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 19,717,359	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,769,805	1
2	Discounts and Allowances for all Levels	(1,106,447)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,663,358	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,251,013	6
7	Oxygen	10,423	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,261,436	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	42,544	13
14	Non-Patient Meals	6,393	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	328	16
17	Sale of Drugs	212,149	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,898	19
20	Radiology and X-Ray		20
21	Other Medical Services	192,118	21
22	Laundry	40,912	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 521,342	23
	D. Non-Operating Revenue		
24	Contributions	25,308	24
25	Interest and Other Investment Income***	451,597	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 476,905	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	198,212	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 198,212	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,121,253	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,465,359	31
32	Health Care	3,141,128	32
33	General Administration	2,648,645	33
	B. Capital Expense		
34	Ownership	589,457	34
	C. Ancillary Expense		
35	Special Cost Centers	1,028,508	35
36	Provider Participation Fee	198,160	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,071,257	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,049,996	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,049,996	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (488,131)	44
45	Private Pay - Net Inpatient Revenue	(5,590,084)	45
46	Medicare - Net Inpatient Revenue	(1,495,524)	46
47	Other-(specify) Insurance/ Managed Care	(89,619)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ (7,663,358)	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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	Description	Amount	
28A	Other Services	33	Adjusted P.5a
28B	Transportation Revenue	7,967	Adjusted P.5a
28C	Other Operating Income	5,897	Adjusted P.5a
28D	Investment Property Revenue	1,954	Adjusted P.5a
28E			
28F			
28G			
28H			
28I			
28J			
28K			
28L			
28M			
28N			
28O			
28P			
28Q			
28R			
28S			
28T			
		15,851	

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,080	$ 95,110	$ 45.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,852	33,935	953,346	28.09	3
4	Licensed Practical Nurses	7,572	8,351	210,926	25.26	4
5	CNAs & Orderlies	77,515	84,941	1,241,910	14.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,422	1,560	58,115	37.25	9
10	Activity Assistants	8,322	8,970	124,526	13.88	10
11	Social Service Workers	5,112	5,594	106,914	19.11	11
12	Dietician					12
13	Food Service Supervisor	869	1,020	20,079	19.69	13
14	Head Cook	6,309	7,060	103,944	14.72	14
15	Cook Helpers/Assistants	16,380	17,129	177,603	10.37	15
16	Dishwashers					16
17	Maintenance Workers	4,237	4,706	112,431	23.89	17
18	Housekeepers	9,157	10,196	132,116	12.96	18
19	Laundry	1,860	2,021	30,100	14.89	19
20	Administrator	1,382	1,586	86,525	54.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,609	10,498	276,367	26.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,512	1,665	41,975	25.21	31
32	Other Health Care(specify)					32
33	Other(specify) Beauty and Barbe	1,056	1,176	19,889	16.91	33
34	TOTAL (lines 1 - 33)	185,094	202,488	$ 3,791,876 *	$ 18.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 29,842	01-3	35
36	Medical Director	Monthly	56,880	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	82	6,132		38
39	Pharmacist Consultant	Monthly	1,363		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	2	150		45
46	Other(specify)				46
47	Laundry Services	Monthly	104,235		47
48					48
49	TOTAL (lines 35 - 48)	84	$ 198,602		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Kaspar	Administrator	0	$ 86,525
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,525

B. Administrative - Other

Description	Amount
Covenant Retirement Communities	$ 428,170
TOTAL (agree to Schedule V, line 17, col. 3)	$ 428,170
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli	Legal	$ 4,060
CSC	Legal	182
CRC	Legal	12,917
Holleran Consultants	Resident Satisfaction Survey	2,638
Jeremy Brune & Associates	Accounting	2,200
FGMK	Accounting	4,650
Sun Solutions	Mock Survey	2,700
Plante Moran	Audit	6,589
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 35,936

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,016
Unemployment Compensation Insurance	7,361
FICA Taxes	283,948
Employee Health Insurance	553,878
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life/Disability Ins.	20,147
Pension Plan Expense	72,739
Other Employee Benefits	2,262
Employee Recognition	6,372
Employee Screening & Annual Physicals	1,556
403B Matching	44,989
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,124,268

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	80,435
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Permits	5,039
Dues and Subscriptions	11,911
Less: Public Relations Expense	( )
Non-allowable advertising	(80,435)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,950

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,821
Seminar Expense	1,611
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,432

* Attach copy of IMRF notifications

**See instructions.

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Account Number	Account Description	Amount
4141-4701-0	Travel And Auto	402
4142-4701-0	Travel And Auto	507
4143-4701-0	Travel And Auto	3,425
4149-4701-0	TRAVEL AND AUTO	2
4170-4701-0	TRAVEL AND AUTO	172
4180-4701-0	Travel And Auto	2,374
4641-4701-0	Travel And Auto	184
4642-4701-0	Travel And Auto	228
4643-4701-0	Travel And Auto	368
4649-4701-0	TRAVEL AND AUTO	1
4670-4701-0	TRAVEL AND AUTO	103
4680-4701-0	TRAVEL AND AUTO	55
		7,821

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN & Leading Age $3305**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,936** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **198,160**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,393**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Plante & Moran**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.